

Appendix A

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MEDICAID FACTSHEET

LONG TERM CARE

LTC Expenditures
as % of Total Medicaid Program:

SFY98:	28.59%
SFY99:	26.83%
SFY00:	26.15%
SFY01:	23.89%
SFY02:	35.23%

TWO LEVELS OF FACILITY CARE:

1. Nursing Facility Services
2. Intermediate Care Facility Services for the Mentally Retarded and Developmentally Disabled (ICF/MR)

Total Skilled Nursing Facility Beds: 24,923

Total ICF/MR Beds: 1,797

There are over 20,061 active Certified Nursing Assistants in Arkansas. The Office of Long Term Care (OLTC) handles the license renewals, approves training sites and programs and maintains records.

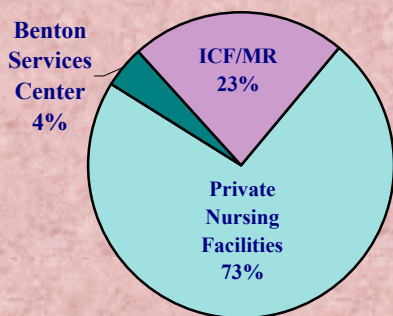
Nursing Facilities: Benton Services Center (public); 230 *private* nursing homes.

ICF/MR: 6 *public* human development centers in Alexander, Arkadelphia, Booneville, Conway, Jonesboro, and Warren.

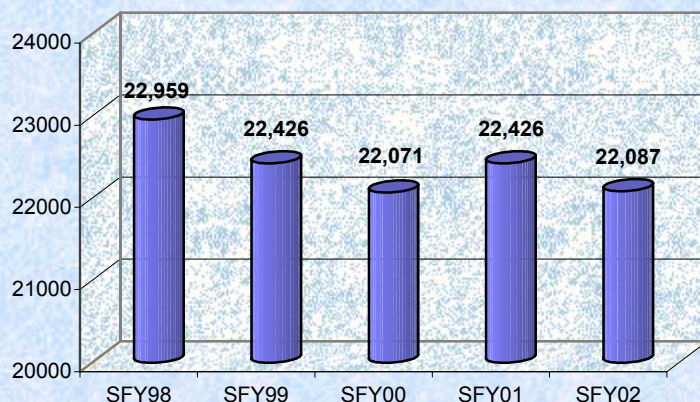
4 *private* pediatric ICF/MR facilities : Arkansas Pediatric, Brownwood, Millcreek and Easter Seals.

30 *private* non-profit ten-bed ICF/MR for adults.

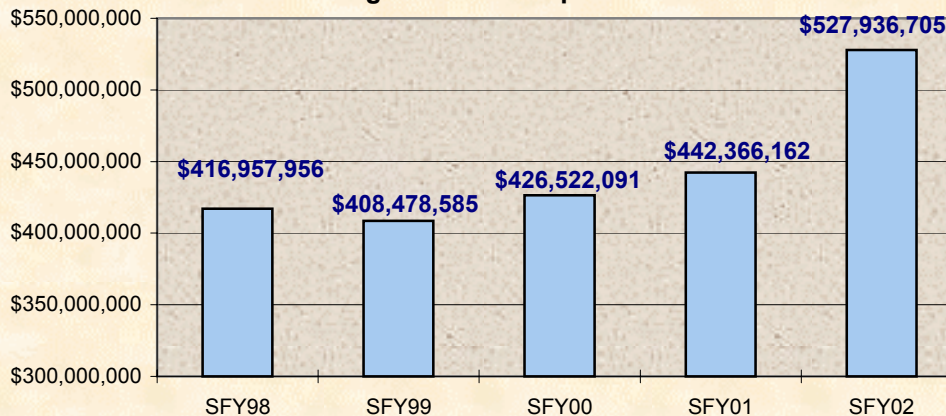
Expenditure Break-Down SFY 02



Long Term Care Recipients



Long Term Care Expenditures



Source: LTC; Dss Reports; HCFA 2082; Medicaid Statistical Reports

MEDICAID FACTSHEET

DDS ACS WAIVER

DDS ACS Waiver Expenditures
as % of Total Hosp/Med Exp:

SFY98:	2.07%
SFY99:	3.13%
SFY00:	3.79%
SFY01:	4.56%
SFY02:	4.32%

Medicaid offers certain home and community based services as an alternative to institutionalization. These services are available for a limited number of eligible individuals with a developmental disability who would otherwise require an ICF/MR level of care. The home and community based services to be provided through this waiver are referred to as the DDS ACS (Alternative Community Services) Waiver.

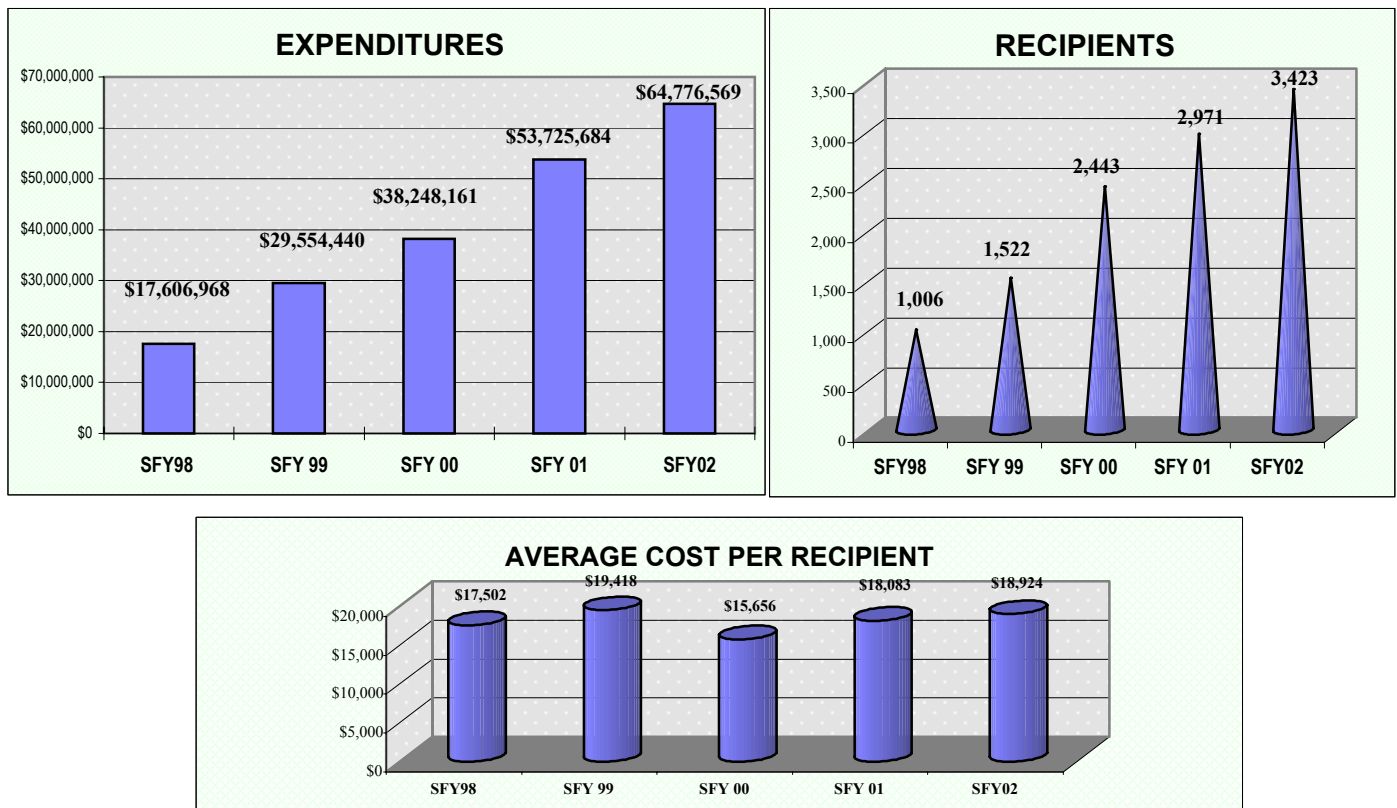
The DDS ACS Waiver is administered by the Division of Developmental Disabilities

Services provided under this program are as follows:

- . Crisis Abatement Respite Care Services
- . Integrated Supports Services
- . Supported Employment Services
- . Physical Adaptation Services
- . Specialized Medical Supplies
- . Case Management Services
- . Consultation Services
- . Crisis Center/Intervention Services

Home and community based waiver services are available only to individuals who are not inpatients (residents) of a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR).

ACS Waiver Program services do not require Prior Authorization.



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET ELDERCHOICES

ElderChoices Expenditures
as % of Total Hosp/Med Exp:

SFY98: 2.66%
SFY99: 2.80%
SFY00: 3.00%
SFY01: 2.74%
SFY02: 2.20%

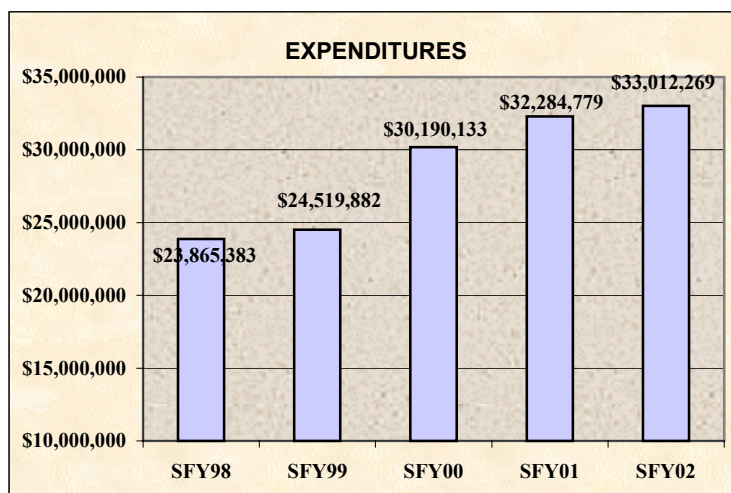
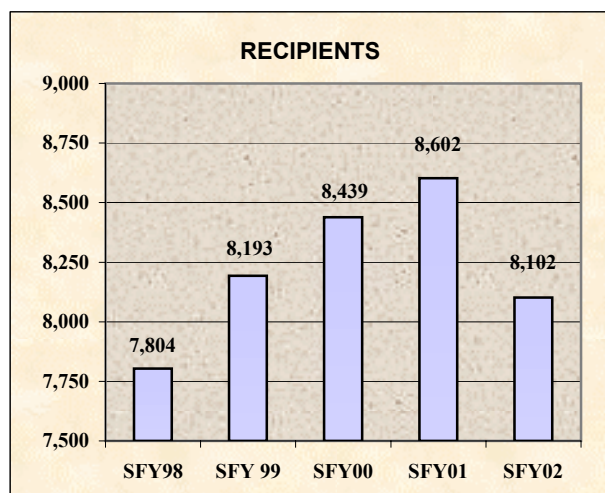
ElderChoices is a home and community based waiver program available to a limited number of individuals ages 65 and older who require an intermediate level of nursing facility care. Services are provided in the patient's home to preclude or delay institutionalization.

ElderChoices services are tailored to the social and medical needs of the recipient through a comprehensive assessment by a registered nurse.

Provided Services:
Adult Foster Care, Chore Services, Home Delivered Meals, Homemaker Services, Personal Emergency Response System, Adult Day Care, Adult Day Health Care, and Respite Care.

ElderChoices became effective July 1991.

AVERAGE COST PER RECIPIENT						
	SFY97	SFY98	SFY99	SFY00	SFY01	SFY02
Number of Recipients	7,681	7,804	8,193	8,439	8,602	8,102
Census of Active EC Cases as of June 30 Each Year			6,194	6,473	6,308	5,867
State General Revenue	\$5,573,552	\$6,455,586	\$6,637,532	\$8,187,564	\$8,710,433	\$8,999,145
Federal Revenue	\$16,667,279	\$17,409,797	\$17,882,350	\$22,002,568	\$23,574,345	\$24,013,125
Total Expenditures	\$22,240,831	\$23,865,383	\$24,519,882	\$30,190,133	\$32,284,779	\$33,012,269
Exp./Recipient	\$2,896	\$3,058	\$2,993	\$3,577	\$3,753	\$4,075



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

Alternatives Waiver

Alternatives Waiver Expenditures
as % of Total Hosp/Med Exp:

- SFY98: 0.11%
- SFY99: 0.37%
- SFY00: 0.59%
- SFY01: 0.70%
- SFY02: 0.76%

Alternatives Waiver services are designed to maintain Medicaid eligible persons at home in order to preclude or postpone institutionalization of the individual.

These services are available to disabled individuals age 21 through 64, who have received a determination of physical disability, and who, without the provision of home and community-based services, would require a nursing facility (NF) level of care. Their income must be equal to or less than 300% of the SSI eligibility limit.

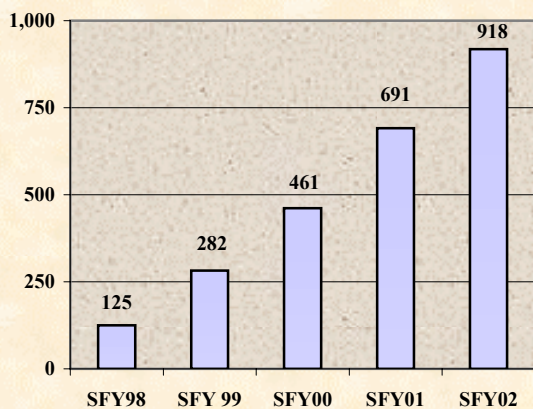
Provided Services:

Attendant Care,
Environmental
Accessibility, and
Adaptations/Adaptive
Equipment

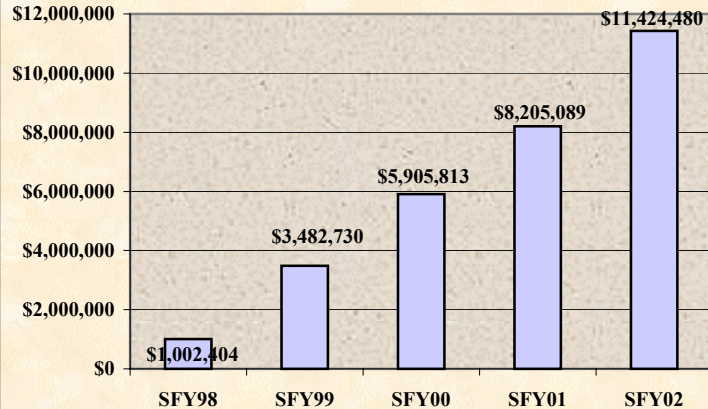
AVERAGE COST PER RECIPIENT

	SFY98	SFY99	SFY00	SFY01	SFY02
Number of Recipients	125	282	461	691	918
Total Expenditures	\$1,002,404	\$3,482,730	\$5,905,813	\$8,205,089	\$11,424,480
Exp./Recipient	\$8,019	\$12,350	\$12,811	\$11,874	\$12,445

RECIPIENTS



EXPENDITURES



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

PERSONAL CARE SERVICES

Personal Care Expenditures as %
of Total Hosp/Med Exp:
SFY98: 7.08%
SFY99: 6.44%
SFY00: 5.74%
SFY01: 4.79%
SFY02: 3.57%

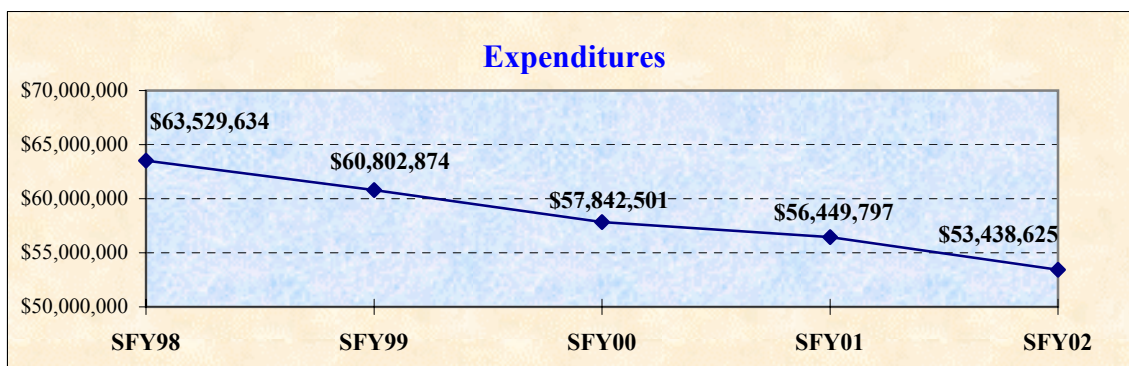
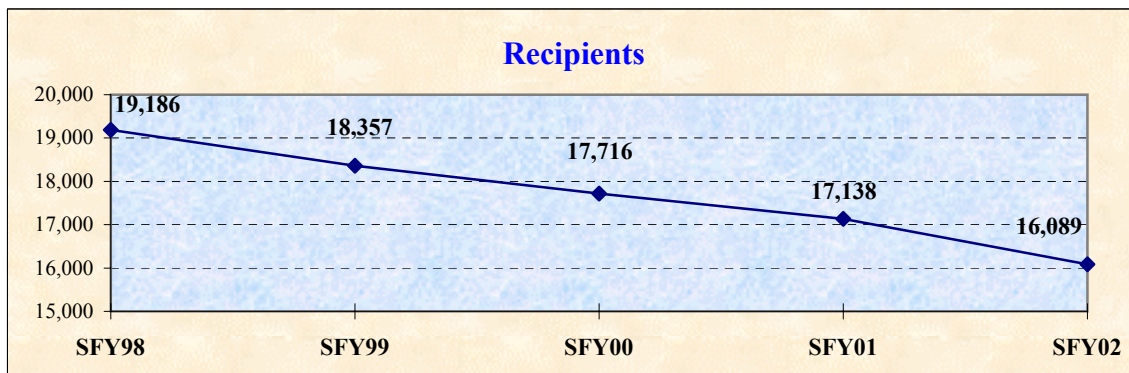
Personal Care Services include medically necessary assistance with defined activities of daily living, such as grooming, bathing, food preparation and eating, etc. Services are rendered in the home.

For EPSDT recipients, under age 21, services may also be provided in DDS community provider facilities or in the public schools. (DDS = Division of Developmental Disabilities Services). Effective for dates of service on and after December 1, 1997, the Arkansas Medicaid Personal Care Program requires prior authorization (PA) of services for clients under the age of 21.

Personal Care Services is an optional program.

Medicaid imposes a 64-hour benefit limit, per month, per client, on personal care aide services for clients aged 21 and over. The 64-hour limitation applies to dates of service on and after August 1, 1997.

The Arkansas Department of Human Services (DHS) is conducting a scientific study of a consumer-directed personal care program. The program, called "IndependentChoices," operates under the authority of an 1115 research and demonstration waiver approved by the Health Care Financing Administration (HCFA). IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care. IndependentChoices provides qualifying clients with counseling and training to assist them in administering their personal care. Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance.

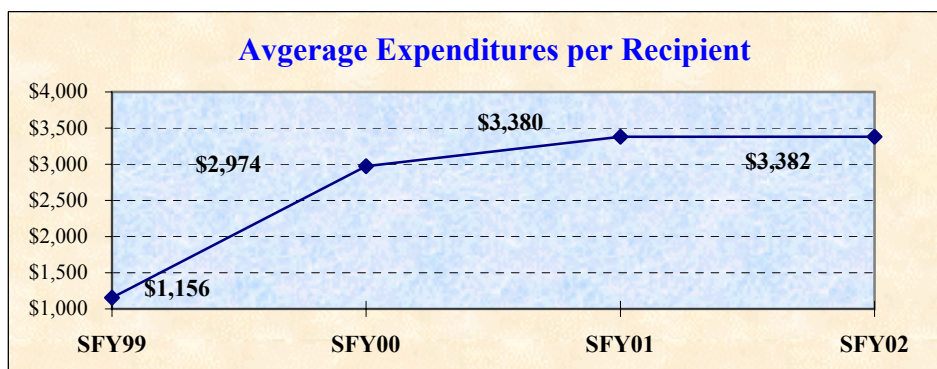
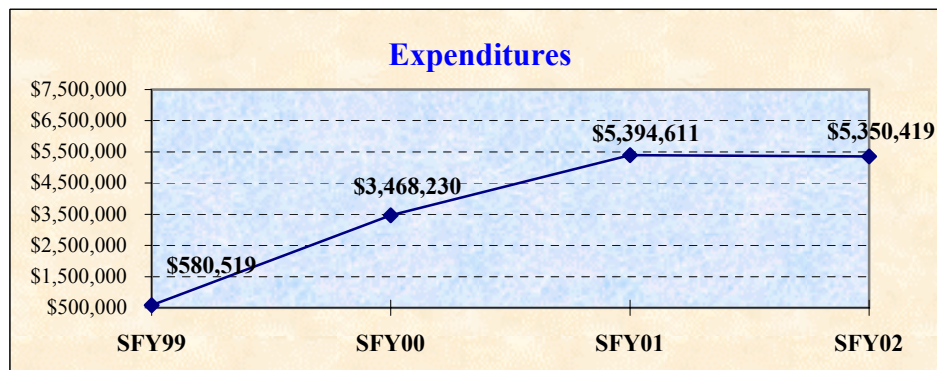
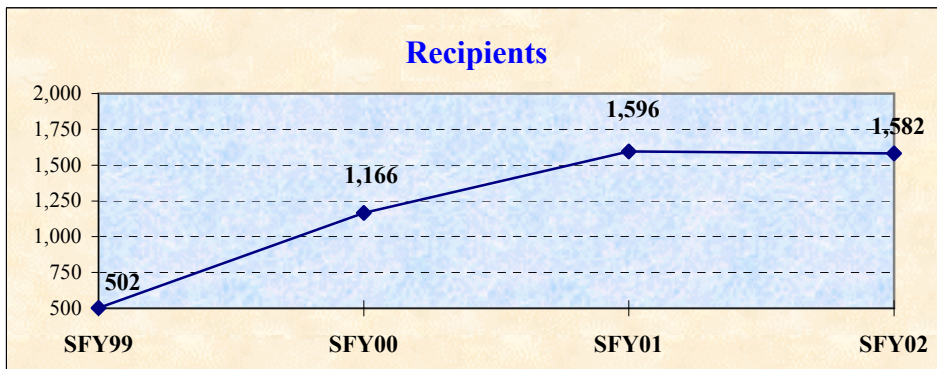


Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET INDEPENDENT CHOICES

Independent Choices
Expenditures as %
of Total Hosp/Med Exp:
SFY99: 0.06%
SFY00: 0.34%
SFY01: 0.46%
SFY02: 0.36%

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care. IndependentChoices provides qualifying clients with counseling and training to assist them in administering their personal care. Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance. IndependentChoices is administered by the Division of Aging and Adult Services (DAAS).



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

HOME HEALTH SERVICES

Home Health Expenditures
as % of Total Hosp/Med Exp:

SFY98: 1.46%
SFY99: 1.48%
SFY00: 1.22%
SFY01: 0.98%
SFY02: 0.71%

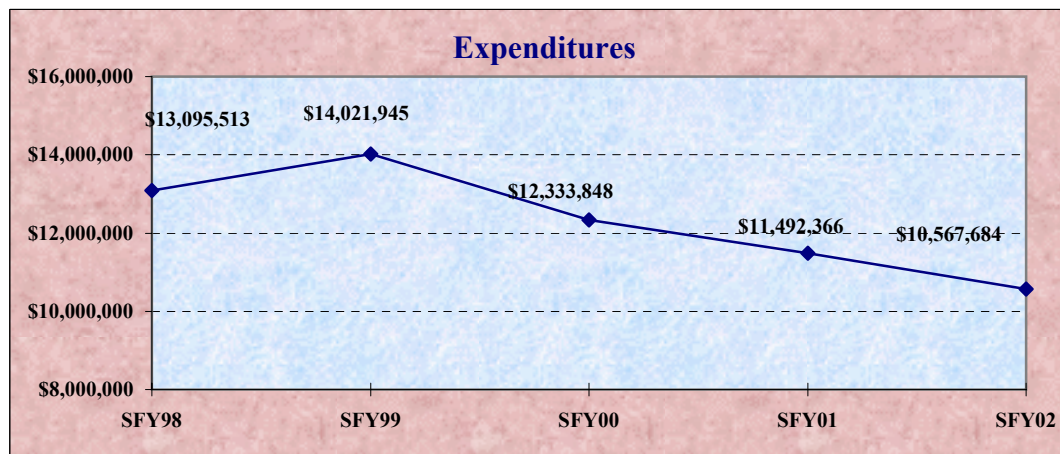
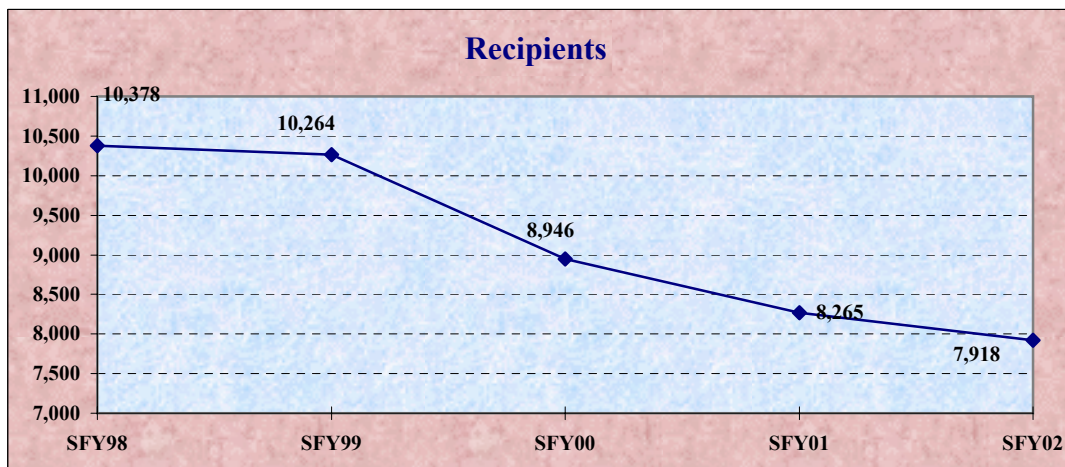
Home Health Services provides skilled nursing, home health aide and physical therapy services in the home.
Services are for part-time, intermittent care, for a few hours a day, one or more times a week.
Services are provided in the patient's residence.

All home health services are based on the patient's attending physician's written prescription. Home health services provide periodic nursing care, under the direction of a physician, to preserve life and prevent or delay the necessity of inpatient care for Medicaid eligible persons.

*Administered by the AR Department of Health and private providers.
Home Health Services is a federally mandated program.*

Benefit limit: 50 visits per State Fiscal Year (extensions may be granted)

The main intent of Home Health Services is to enable individuals to remain in their homes, thereby reducing the need for costly institutional care.
PCP Referral Required.



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET PRIVATE DUTY NURSING

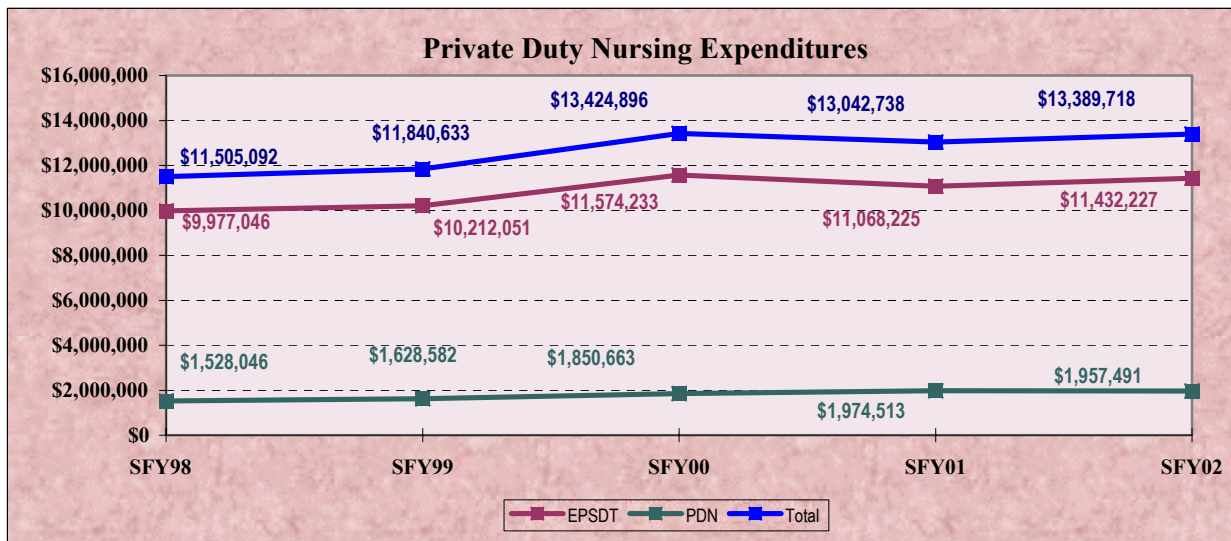
Private Duty Nursing Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.28%
SFY99: 1.26%
SFY00: 1.33%
SFY01: 1.11%
SFY02: 0.89%

Private Duty Nursing (PDN) Services are provided by a registered nurse and/or licensed practical nurse under the direction of the recipient's physician. Services are rendered in the recipient's place of residence.

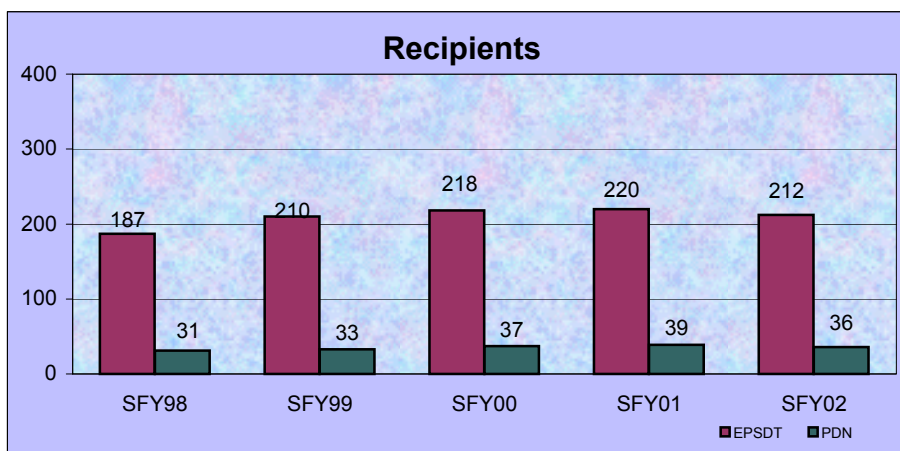
Private Duty Nursing Services are *not* covered in a hospital, boarding home, intermediate care facility, skilled nursing facility or a residential care facility. \$80 per month, per recipient benefit limit on Private Duty Nursing medical supplies; limit may be extended.

ELIGIBILITY

PDN services may be covered for Medicaid eligible ventilator-dependent recipients when determined medically necessary and prescribed by a physician. Coverage may also be available for high technology non-ventilator dependent recipients in the Child Health Services Program (EPSDT) who require: Prolonged Intravenous Drugs; Parenteral Nutrition; Oxygen Supplementation; Tube Feeding; and Peritoneal Dialysis.



EPSDT = Private Duty Nursing/EPSDT; PDN = Private Duty Nursing, non-EPSDT



Average Expenditure Per Recipient, SFY02

EPSDT	\$53,926
PDN	\$54,375
Total	\$53,991

Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

DDTCS

DDTCS Expenditures
as % of Total Hosp/Med Exp:
SFY98: 4.73%
SFY99: 4.80%
SFY00: 5.19%
SFY01: 4.76%
SFY02: 4.14%

Services must be rendered at a Comprehensive Day Treatment Center:

- * diagnosis and evaluation
- * habilitative training
- * provision of noon meal

Services in qualified facilities may be covered only when:

- * they are provided to outpatients
- * they are determined medically necessary
- * provided according to written prescription
- * provided according to written plan of care

Administered by the Division of Development Disabilities

Levels of Care:

1. Early Intervention: facility based provision of one-to-one staff/client training in conjunction with services to parents/care-givers of the client
2. Pre-School: facility based program for children up to 5 years of age
3. Adult Development: facility based program for adults

Optional Services available through DDTCS are as follows:

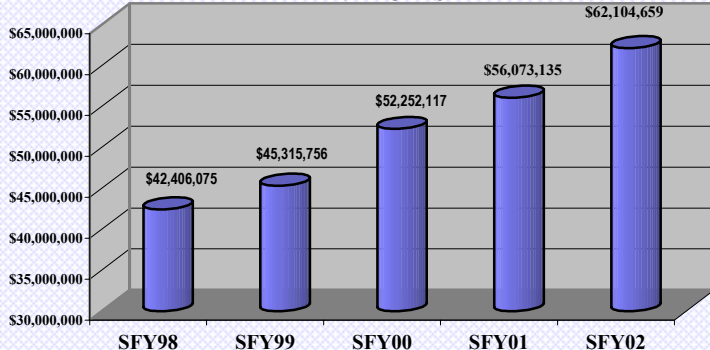
(Must be in conjunction with a core service)

- . physical therapy
- . speech therapy
- . occupational therapy
- . therapy evaluations (PT, OT and ST)

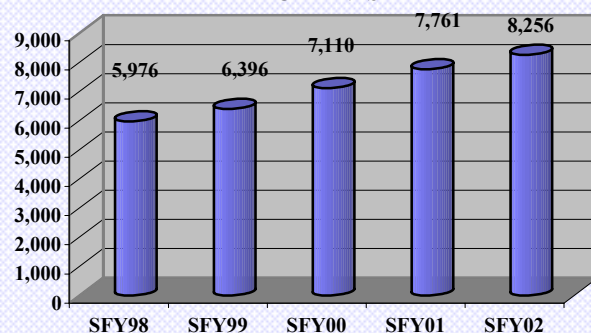
Non-covered Services (not limited to):

- . Adult Development Services, Pre-School Services and Diagnosis and Evaluation Services less than 1 hour
- . Early Intervention Services less than 2 hours
- . Supervised Living Services
- . Educational Services
- . Services to Inpatients

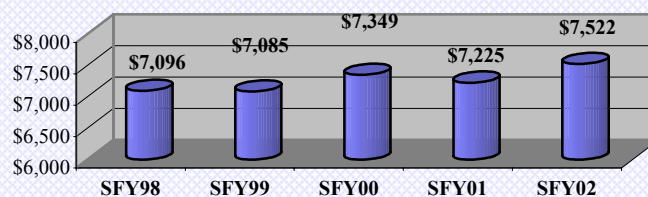
EXPENDITURES



RECIPIENTS



AVERAGE COST PER RECIPIENT



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

CASE MANAGEMENT

Case Management Expenditures
as % of Total Hosp/Med Exp:

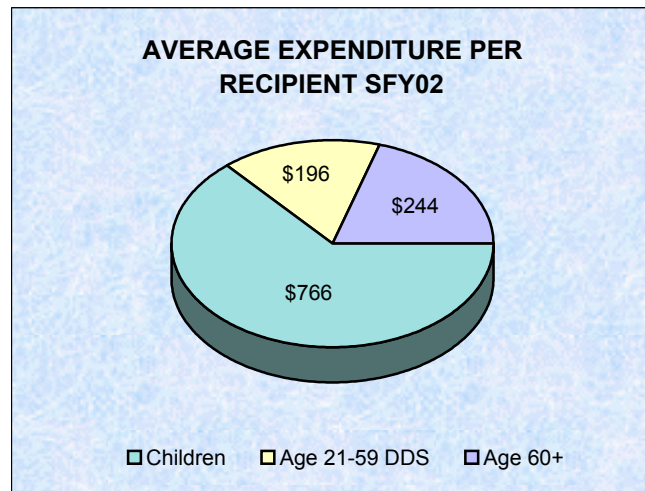
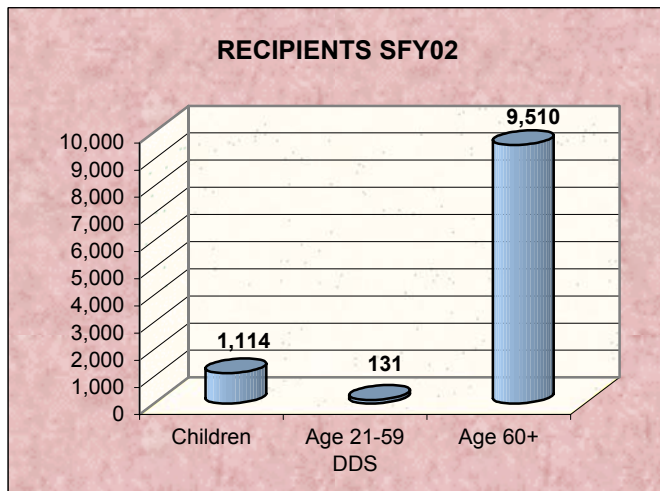
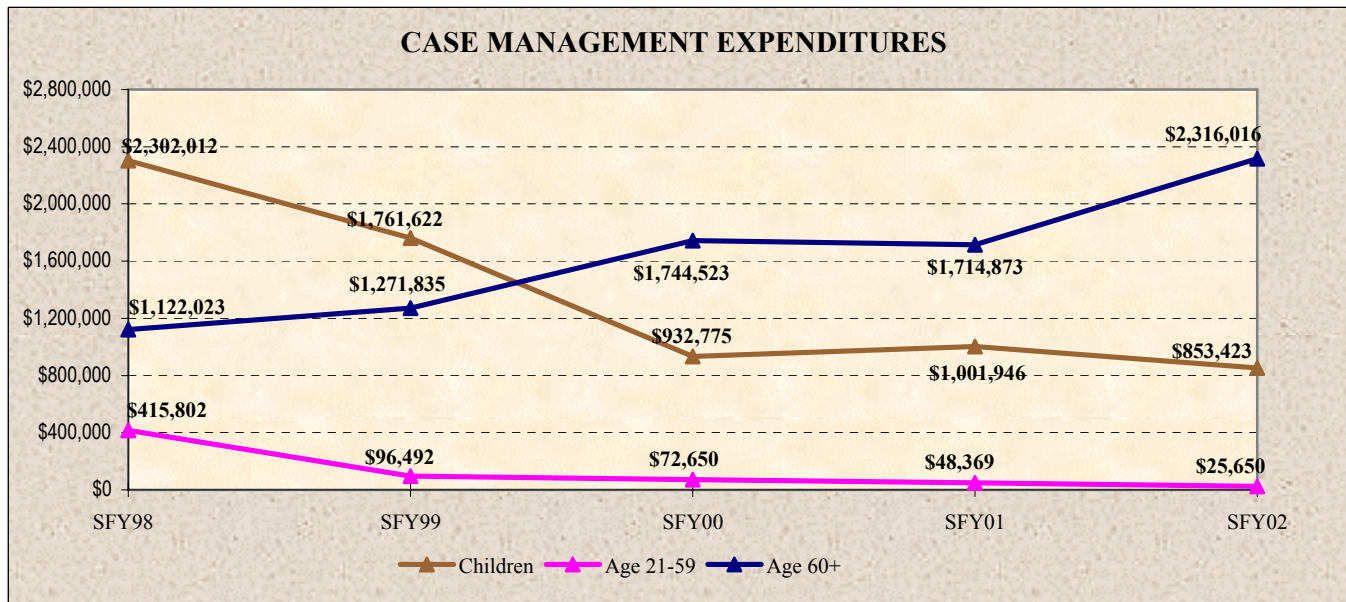
SFY98:	0.43%
SFY99:	0.33%
SFY00:	0.27%
SFY01:	0.23%
SFY02:	0.21%

Case Management is designed to assist individuals in receiving necessary care and to coordinate services for those individuals. Recipients age 21 and older are limited to 208 hours of targeted case management services per fiscal year. There is no benefit limit for recipients under age 21.

Case Management services are reimbursable when they are medically necessary, prescribed as the result of an EPSDT screen for recipients under age 21 ineligible for Developmental Disabilities Services, provided to recipients who have no reliable and available supports, and provided by a qualified provider enrolled to serve the recipient's targeted population. Case Management services to inpatients are not covered - inpatient facilities provide discharge planning.

Case Management is also reimbursable for:

- * individuals age 21 and younger eligible for Developmental Disabilities Services
- * individuals age 22 and older with a developmental disability
- * individuals age 60 and older who have limited functional capabilities resulting in the need for multiple services or who are not of mental capacity to understand their situation poses an imminent danger of death or serious bodily harm.



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

HOSPICE SERVICES

Hospice Expenditures
as % of Total Hosp/Med Exp:
SFY98: 0.34%
SFY99: 0.27%
SFY00: 0.29%
SFY01: 0.31%
SFY02: 0.34%

Definition:

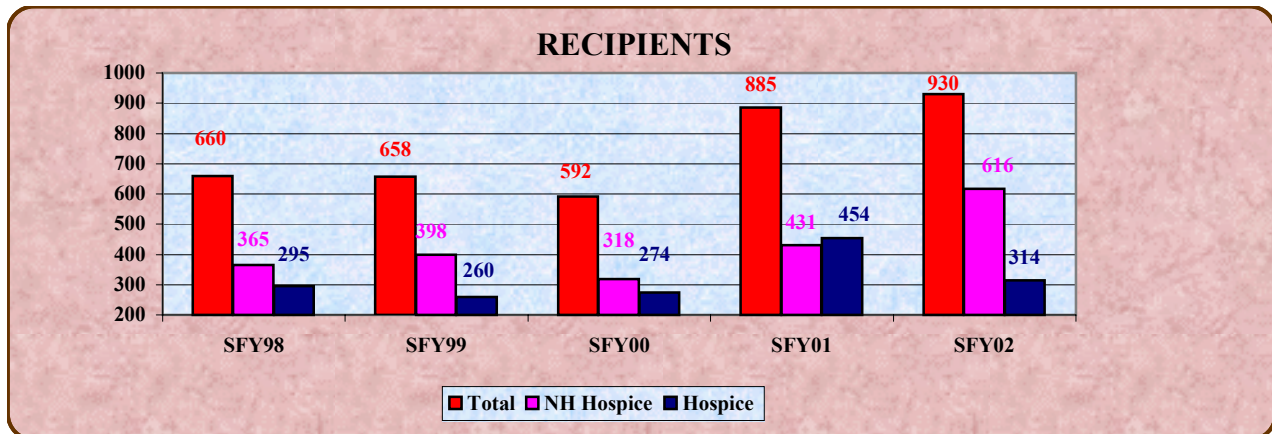
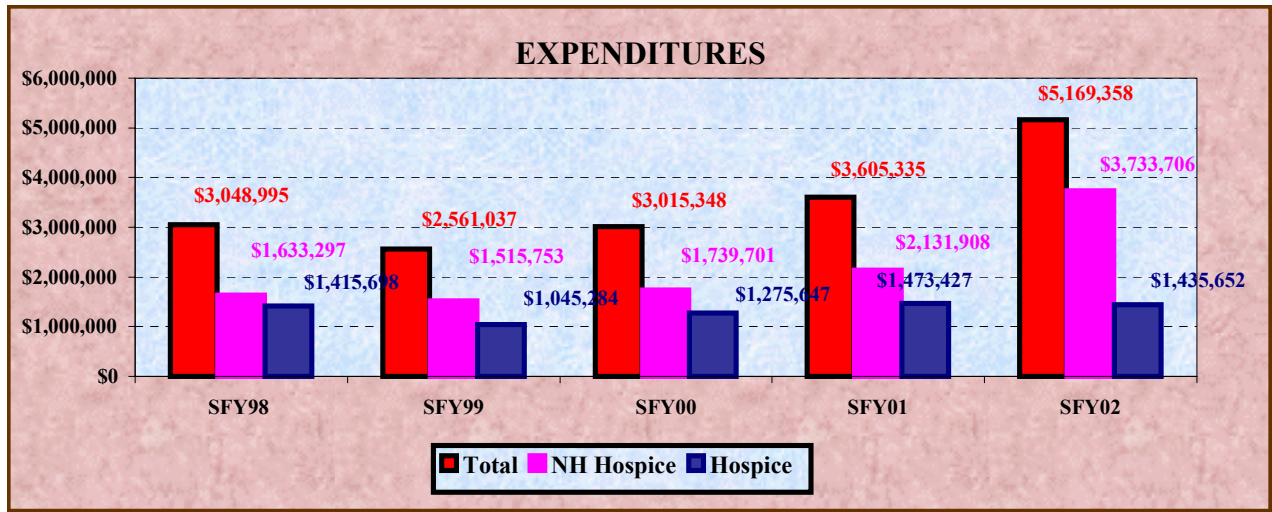
Hospice is a continuum of care, directed by professionals, designed to meet the needs & desires of those who are terminally ill & for whom curative medicine has exhausted its possibilities. Hospice services are reasonable & medically necessary services,

Eligibility:

- * Patients of all ages are eligible; Dual eligibles must reside in a Nursing Facility
- * Patient must have terminal illness with life expectancy of six months or less
- * Patients elect to receive hospice services instead of certain other Medicaid Benefits
- * Hospice services must be provided primarily in patient's residence

A patient may elect to receive hospice services in a nursing facility under specific agreement; or, in a hospital or nursing facility if the facility is an enrolled Medicaid Hospice provider. Hospice providers must have an interdisciplinary staff and volunteer assistants. Volunteer hours must be equivalent to at least five percent of the total compensated patient care hours.

Reimbursable Hospice Services: nursing care; social workers; physician services; counseling services to patient/family/care givers; medical appliances & supplies including drugs; home health aide services; certain physical, occupational & speech therapy services; continuous home care during crisis period; inpatient respite care; general inpatient care



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

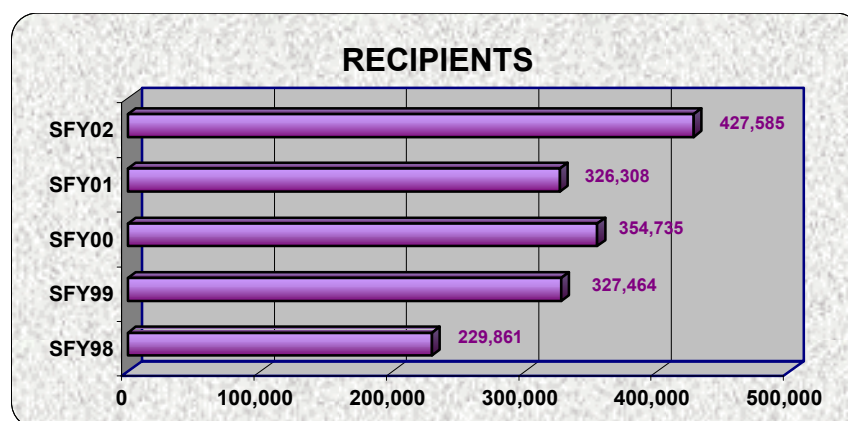
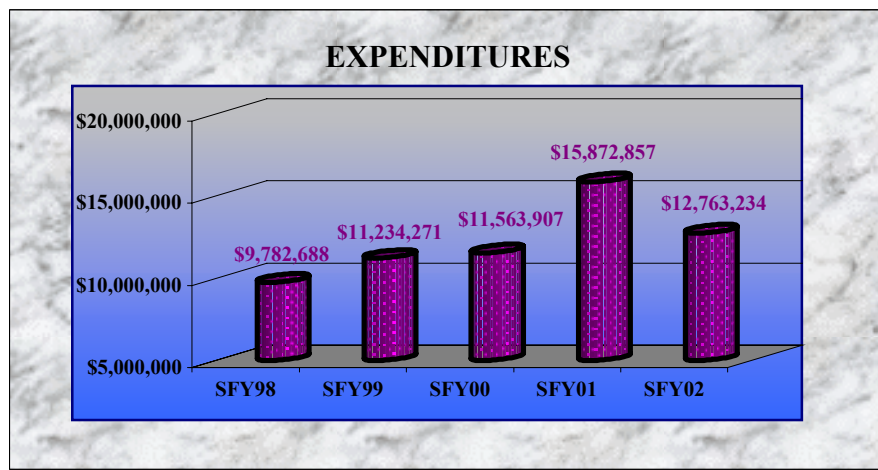
TRANSPORTATION

Transportation Expenditures
as % of Total Hosp/Med Exp:

SFY98:	1.09%
SFY99:	1.19%
SFY00:	1.15%
SFY01:	1.35%
SFY02:	1.08%

Non-Profit and Public Transportation is covered when the recipient is transported to or from a medical facility to receive covered services, when transportation is not otherwise available, for the least expensive available means suitable to the recipient's medical needs, to deliver individuals to the nearest qualified providers who are generally available and used by other residents of the community (unless the patient is referred by a physician to a provider that is outside of the general area).

If there is more than one recipient transported at the same time to the same location, Medicaid may be billed for only one recipient; if there is more than one recipient transported at the same time to different locations, the provider may bill only for the recipient traveling the farthest distance.



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET **MENTAL HEALTH SERVICES**

Mental Health Expenditures
as % of Total Hosp/Med Exp:

SFY98: 13.59%
 SFY99: 13.64%
 SFY00: 13.18%
 SFY01: 12.44%
 SFY02: 12.86%

Mental Health Services are provided by Inpatient Psychiatric Facilities and Outpatient Services (RSPMI).

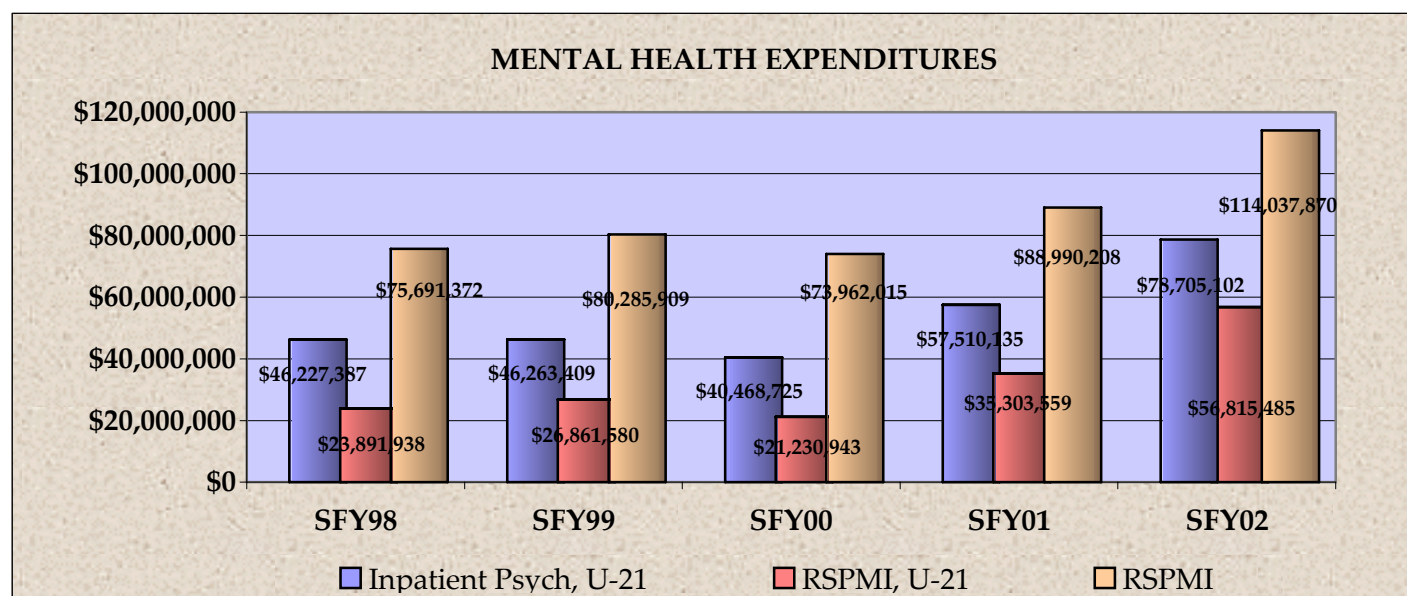
Inpatient Psychiatric Services are for recipients up to the age of 21; elective admissions require pre-certification by an independent certification team (First Mental Health, Inc., Nashville, TN).

Outpatient Services for Rehabilitative Services for Persons with Mental Illness (RSPMI) are provided by Community Mental Health Centers.

RECIPIENTS	SFY98	SFY99	SFY00	SFY01	SFY02
Inpatient Psych, U-21	3,155	3,442	3,226	4,015	4,898
RSPMI	24,787	27,436	28,692	33,723	40,517
Total	27,942	30,878	31,918	37,738	45,415

EXPENDITURES	SFY98	SFY99	SFY00	SFY01	SFY02
Inpatient Psych, U-21	\$ 46,227,387	\$ 46,263,409	\$40,468,725	\$57,510,135	\$78,705,102
RSPMI	\$ 75,691,372	\$ 80,285,909	\$73,962,015	\$88,990,208	\$114,037,870
Total	\$ 121,918,759	\$ 126,549,318	\$114,430,740	\$146,500,343	\$192,742,973

RSPMI, U-21	SFY98	SFY99	SFY00	SFY01	SFY02
RECIPIENTS	12,080	13,407	14,080	18,831	24,902
EXPENDITURES	\$23,891,938	\$26,861,580	\$21,230,943	\$35,303,559	\$56,815,485



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual; HCFA 2082

MEDICAID FACTSHEET PSYCHOLOGIST SERVICES

Psychologist Svcs. Expenditures
as % of Total Hosp/Med Exp:

SFY98:	0.10%
SFY99:	0.09%
SFY00:	0.08%
SFY01:	0.09%
SFY02:	0.09%

The Psychology Program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed psychologist to Medicaid eligible clients **under the age of 21** who suffer from psychiatric conditions as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM III) and subsequent revisions.

Covered Psychology Services:

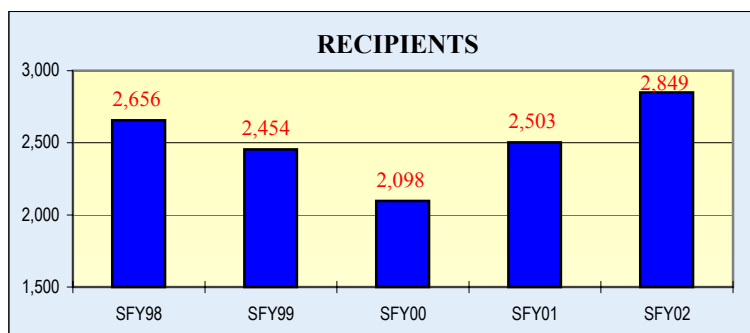
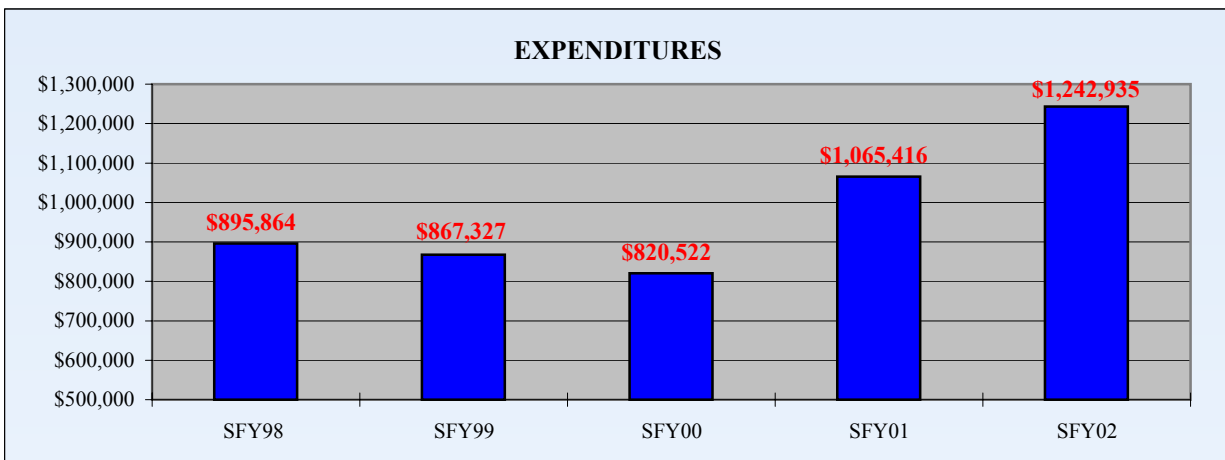
- * prescribed by a physician
- * provided to outpatients
- * provided by licensed psychologist
- * when applicable, provided according to an Individualized Education Plan

Services covered when provided in:

- * provider's office
- * outpatient acute care hospital setting
- * public school system setting under authority of Arkansas Department of Education

Psychology services are not available to inpatients. Psychologist may not bill for services provided in a Community Mental Health Clinic or an inpatient psychiatric facility (the individual facility must bill through their respective program).

Covered services include: diagnosis; psychological testing/evaluation; interpretation of diagnosis; crisis management visits; individual outpatient therapy sessions; marital/family therapy; group outpatient therapy.



Recipients by Age, SFY02:

Under 1	2
Ages 1 - 5	321
Ages 6 - 14	2,005
Ages 15 - 20	521

Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

PROSTHETICS/DME

Expenditures for Prosthetics/DME
as % of Total Hosp/Med Exp:

SFY98:	0.74%
SFY99:	0.94%
SFY00:	0.99%
SFY01:	0.97%
SFY02:	0.91%

Prosthetics Services are defined as durable medical equipment/oxygen, orthotic appliances, prosthetic devices, augmentative communication devices, specialized wheelchairs, wheelchair seating systems and specialized rehabilitative equipment. Prosthetics services may include any or all of these services.

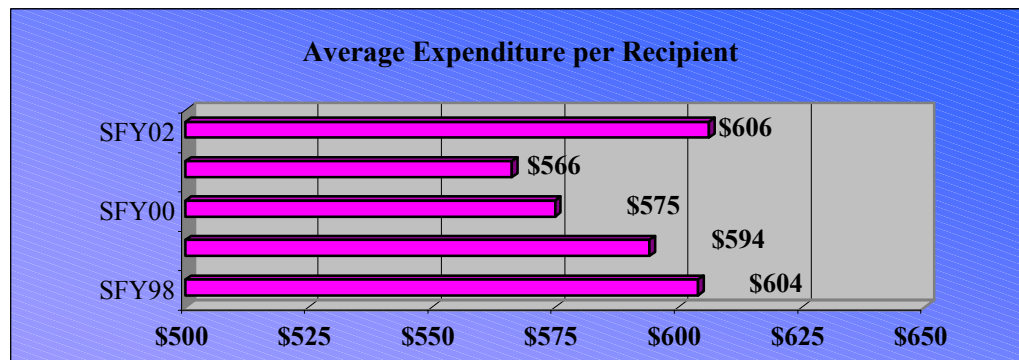
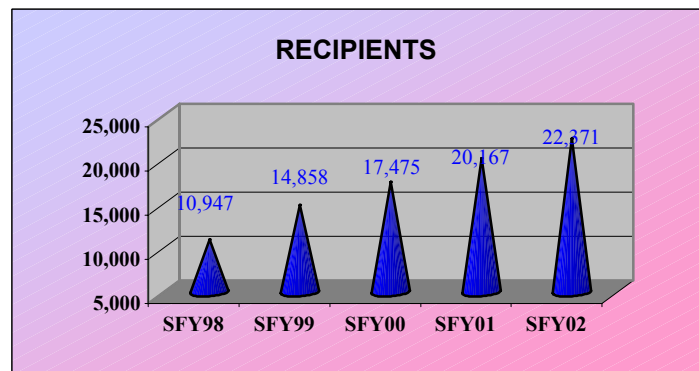
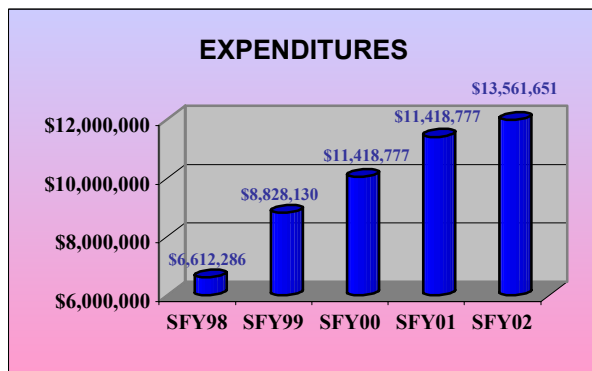
Services must be medically necessary and prescribed by the recipient's Primary Care Physician (PCP) unless the recipient is exempt from PCP requirements. Specified services are covered for recipients of all ages. Certain services are covered only for recipients under age 21 in the EPSDT Program. Where applicable, Prior Authorization is required.

In order to be covered for services, a recipient's place of residence may not include a hospital, a skilled nursing facility, intermediate care facility or any other supervised living setting which is required to provide prosthetic services.

Non-Covered Services:

- * Orthotic appliances and prosthetic devices for recipients over age 21
- * Over-the-counter items provided through the Pharmacy Program
- * Over-the-counter drugs
- * Specialized wheelchair equipment which has ever been previously purchased for the recipient
- * Wheelchairs for recipients under age 21 within two years of the purchase of a specialized wheelchair
- * food stuffs; hyperalimentation

At least once every 6 months, the Primary Care Physician must certify medical necessity for prosthetics



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET THERAPY SERVICES

Therapy Services Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.74%
SFY99: 1.85%
SFY00: 2.05%
SFY01: 2.18%
SFY02: 2.14%

***** Therapy Services encompass Physical Therapy,
Occupational Therapy, and Speech Pathology Services *****

Therapy Services provided according to physician referral to Medicaid eligibles under age 21 under the EPSDT Program

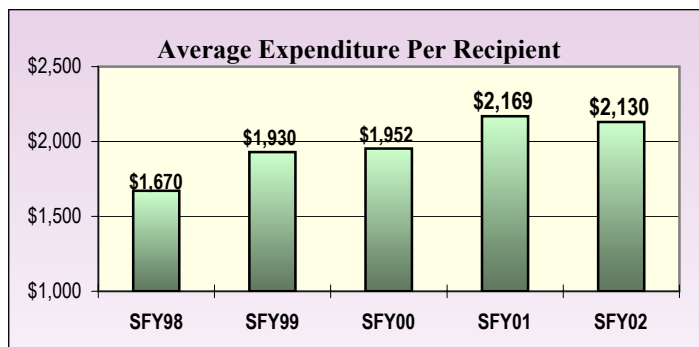
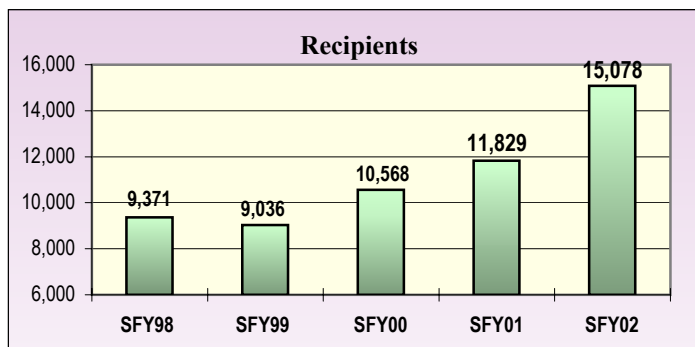
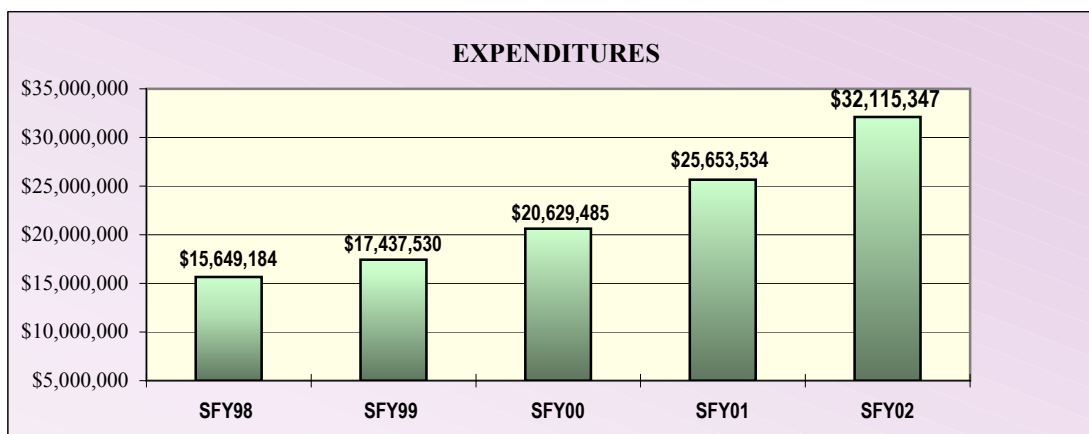
Individuals who have been admitted as an inpatient to a hospital and/or are residing in a nursing care facility are not eligible for occupational therapy, physical therapy, and speech pathology services under this program. Prior authorization is required for therapy services.

Scope of Therapy Services: *Services covered only when these conditions exist...*

1. Services provided by appropriately licensed individuals enrolled as Medicaid providers.
2. Services provided as a result of a referral from the recipient's PCP or attending physician.
3. Treatment services must be provided according to a written prescription signed by the recipient's PCP or attending physician.
4. Treatment services must be provided according to a treatment plan or plan of care for the prescribed therapy.

<i>Therapist Counts SFY02</i>	<i>Physical Therapists</i>	<i>Occupational Therapists</i>	<i>Speech Pathologists</i>
Individual Therapists	494	381	721
Group Therapists	416	332	391
School Therapy	89	83	174

<i>Recipient Counts (counts are duplicated between categories) : SFY 02</i>	
Physical Therapy	7,466
Occupational Therapy	3,098
Speech Therapy	8,023



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET

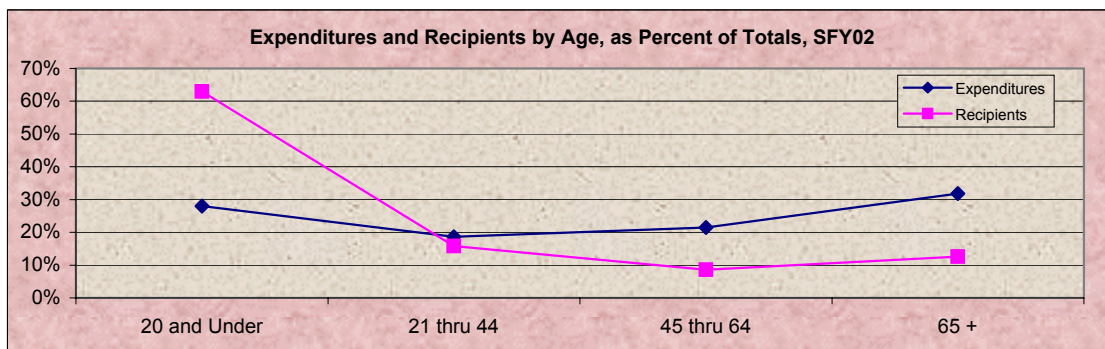
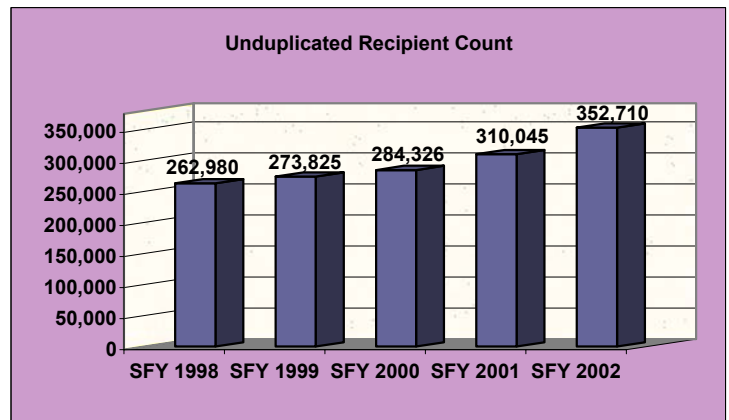
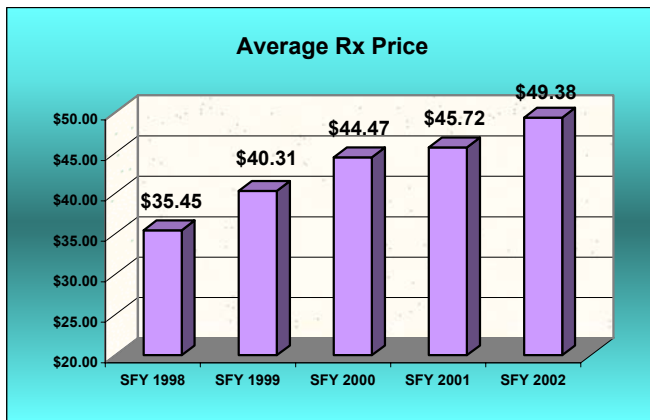
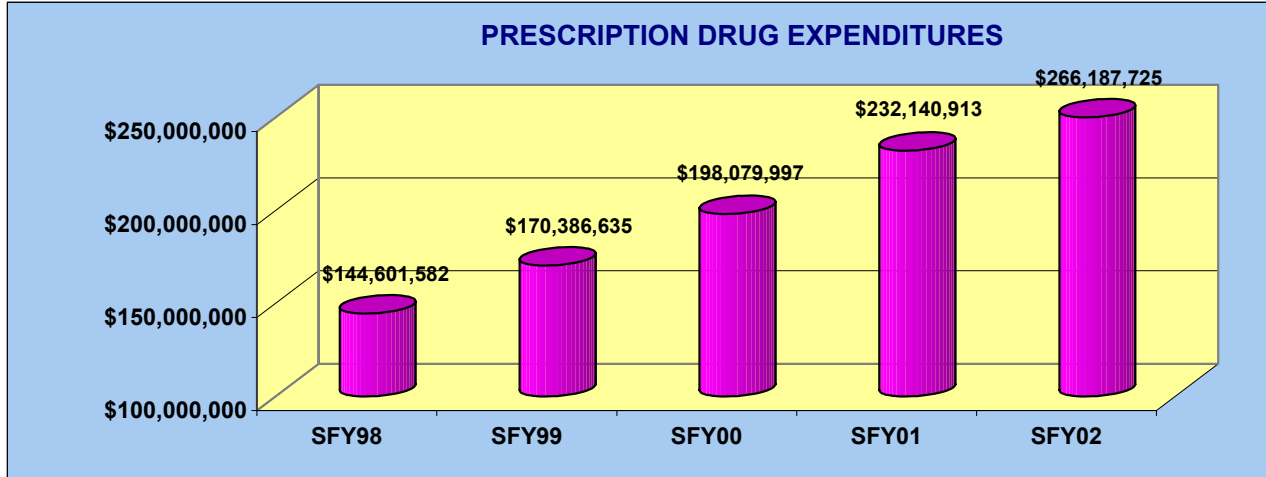
PRESCRIPTION DRUGS

Rx Drug Expenditures as %
of Total Hosp/Med Exp:
SFY98: 16.12%
SFY99: 18.06%
SFY00: 19.68%
SFY01: 19.71%
SFY02: 17.76%

Three prescriptions per recipient per month (extensions possible); family planning items do not count against limit. No limit for children under 21 (EPSDT) and certified nursing home residents.

**757 Participating Pharmacies available
to Medicaid recipients in SFY 02.**

Medicaid Drug Rebate Program created by OBRA, 1990 - law requires that Medicaid reimburse only for drugs manufactured by pharmaceutical companies that have signed rebate agreements. Approximately 670 drug companies participate. The Rebate Program gives Medicaid the equivalent of large volume purchasing advantages.



MEDICAID FACTSHEET

EPSDT

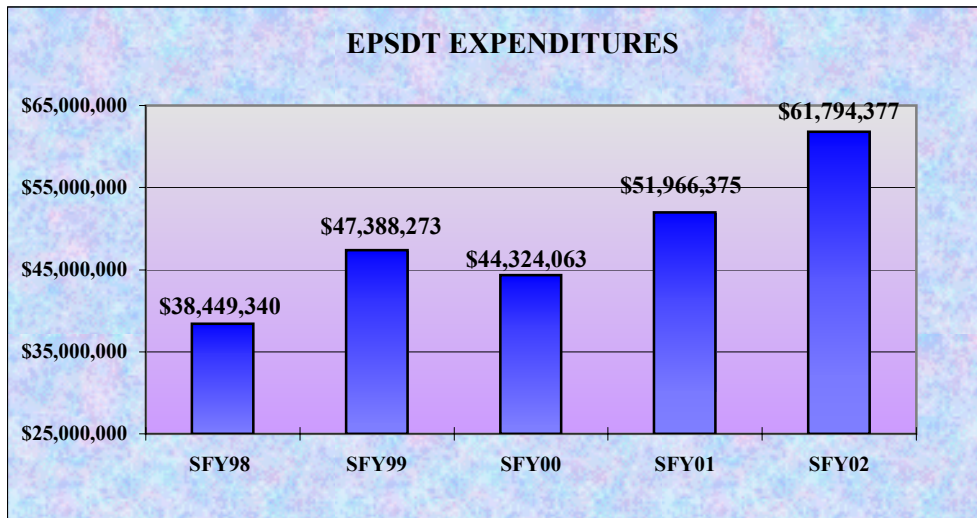
EPSDT Expenditures
as % of Total Hosp/Med Exp:
SFY99: 5.02%
SFY00: 4.40%
SFY01: 4.41%
SFY02: 4.12%

The Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated child health component of Medicaid. EPSDT is designed to ensure comprehensive health care to individuals under the age of 21 (even if the individual is a parent) who are eligible for medical assistance. Arkansas' medical periodic screening schedule follows the American Academy of Pediatrics recommendations. Health professionals who do EPSDT screenings may diagnose and treat health problems identified during the screening or may refer the child to other sources of care. Treatment for conditions discovered during a screen may exceed limits of the Medicaid Program.

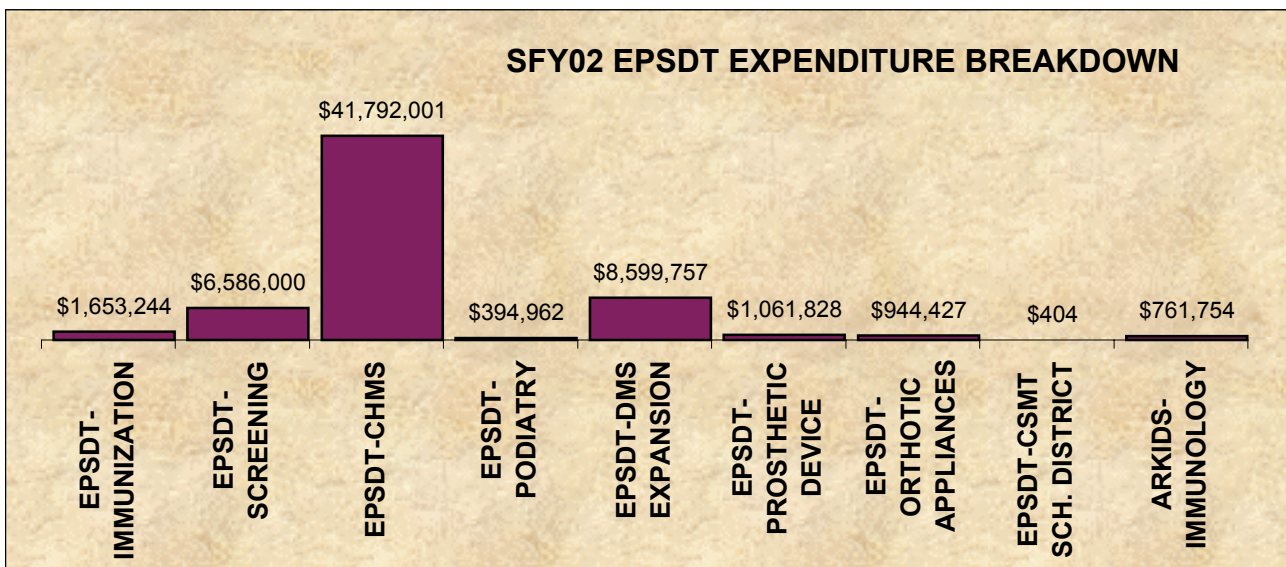


Screening Components

Health and developmental history, physical examination, developmental assessment, visual and hearing evaluations, dental health assessment, blood lead testing, nutritional assessment, and health education.



155,688 Recipients
SFY02



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

Number of consumers served and costs of services in various Arkansas Rehabilitation Services programs

Program	Case costs per fiscal year							
	1998		1999		2000		2001	
	Number	Costs	Number	Costs	Number	Costs	Number	Costs
VR	19,578	\$17,532,558	22,479	\$21,101,403	22,822	\$20,609,584	23,322	\$21,332,284
HSRC	1,032	\$13,409,610	842	\$12,010,507	847	\$13,019,511	902	\$13,558,655
ODHI-VR	1,497	\$2,792,280	1,171	\$2,871,353	1,380	\$3,063,584	670	\$1,889,005
Title VII-IL Services	--	--	730	\$554,236	732	\$554,236	670	\$554,236
Supported Employment	101	\$245,410	246	\$298,919	250	\$474,450	248	\$227,990
CRPs	1,328	\$1,382,661	1,284	\$1,334,005	1,355	\$1,342,674	1,338	\$1,320,874
ACES	--	--	116	\$489,246	234	\$712,663	271	\$633,364
ICAN	4,434	\$876,777	2,791	\$367,878	1,447	\$308,629	1,707	\$377,393
CADET	--	--	--	--	--	--	96	\$216,183

Arkansas Rehabilitation Services Program Descriptions

Vocational Rehabilitation (VR). Arkansas Rehabilitation Services provides vocational rehabilitation services to Arkansans with mental, physical and sensory disabilities to enable them to obtain and keep meaningful jobs. Services include counseling and evaluation to ensure a client's strengths are identified and maximized, physical restoration and medical services to prepare clients physically, academic and vocational training to obtain high quality jobs commensurate with their aspirations and abilities, and the equipment to ensure clients are adequately prepared to enter the workplace.

Hot Springs Rehabilitation Center (HSRC). HSRC is a unique facility offering a range of comprehensive services to Arkansans with disabilities. The Center offers two core programs: the Arkansas Career Training Institute and the Hot Springs Rehabilitation Hospital.

Office of Deaf and Hearing Impaired (ODHI-VR). ODHI provides vocational rehabilitation services to Arkansans who are deaf or hearing impaired. Services provided are as listed above for VR.

Office of Deaf and Hearing Impaired Independent Living Services (Title VII-IL Services). This program provides independent living services to Arkansans who are Deaf or Hearing Impaired. Services include training and assistive devices intended to make the individual more independent in the activities of daily living.

Supported Employment. Supported employment services, including a job coach, are provided to individuals with a disability to assist them in gaining and keeping competitive jobs at or above the minimum wage. This service is available through a network of non-profit providers.

Community Rehabilitation Programs (CRPs). CRPs provide assessment/evaluation, work adjustment and extended services training for Arkansas Rehabilitation Services referred consumers in a vocationally relevant work oriented environment. The program provides basic employability/job readiness skills training, independent living skills training, transportation services, supervised off-site mobile work crews, work enclaves, target specific vocational training, and direct job placement assistance. These services are provided through a statewide network of community providers.

Arkansas Consortium for Employment Success (ACES). ACES is a system change grant program funded by the Rehabilitation Services Administration, U.S. Department of Education (OSERS). This program works with the Social Security Administration to provide vocational rehabilitation services to individuals who have applied for Social Security Disability Insurance in an effort to divert them to employment before they begin to receive benefits. TANF recipients are also eligible to participate in this program.

Increasing Capabilities Access Network (ICAN). The Increasing Capabilities Access Network provides activities that assist the State in maintaining and strengthening a permanent, comprehensive statewide program of technology-related assistance for individuals with disabilities of all ages. Services include capacity building, advocacy, information/referral, outreach, public awareness, training, demonstrations, used equipment exchange and equipment loan programs.

Telecommunications Access Program (TAP). This program provides access to telecommunications equipment to eligible Arkansans who are deaf, hard of hearing, or speech impaired or who have any other disability that prevents them from accessing the telecommunications system.

Low Interest Loan. A low interest loan fund was established in 1989 to assist individuals with a disability to purchase assistive technology. The original fund was used as match for a federal grant in 2002 to expand the fund to \$1.6 million. The new, expanded loan fund is called the Arkansas Assistive Technology Alternative Financing Program.

Creative Alternatives for Delta Area Transportation (CADET). CADET is a \$1,375,000 grant over five years to provide transportation services to people with disabilities in the Delta area to assist them in preparing for, obtaining and maintaining employment as well as to enhance and expand the transit system for the future.

Institutional Services Counts and Cost

Type of Facility	Midnight Census Count 06/30/02	SFY02 Unduplicated Recipient Count	SFY02 Incurred Expenditure Cost
Nursing Homes	12,898		\$368,316,025.12
Arkansas Health Center	304		\$22,743,822.81
Human Development Centers	1,161	1,238	\$84,508,060.44
Pediatric Facilities	197	240	\$16,972,946.39
Ten Bed	343	393	\$20,402,546.03
Total:	14,903	1,871	\$512,943,400.79

Type of Facility	Midnight Census Count 06/30/01	SFY01 Unduplicated Recipient Count	SFY01 Incurred Expenditure Cost
Nursing Homes	13,375		\$292,638,298.42
Arkansas Health Center	301		\$21,265,038.39
Human Development Centers	1,215	1,283	\$86,833,541.91
Pediatric Facilities	202	243	\$16,211,380.57
Ten Bed	356	387	\$20,432,125.58
Total:	15,449	1,913	\$437,380,384.87

Type of Facility	Midnight Census Count 06/30/00	SFY00 Unduplicated Recipient Count	SFY00 Incurred Expenditure Cost
Nursing Homes	13,840		\$274,454,763.60
Arkansas Health Center	309		\$22,601,655.76
Human Development Centers	1,231	1,284	\$89,454,381.86
Pediatric Facilities	202	240	\$15,595,926.30
Ten Bed	360	1,524	\$20,325,453.37
Total:	15,942	3,048	\$422,432,180.89

Type of Facility	Midnight Census Count 06/30/99	SFY99 Unduplicated Recipient Count	SFY99 Incurred Expenditure Cost
Nursing Homes	14,206		\$259,598,275.45
Arkansas Health Center	319		\$21,554,688.94
Human Development Centers	1,231	1,266	\$85,384,910.62
Pediatric Facilities	202	233	\$14,171,512.01
Ten Bed	358	383	\$19,517,929.16
Total:	16,316	1,882	\$400,227,316.18

Type of Facility	Midnight Census Count 06/30/98	SFY98 Unduplicated Recipient Count	SFY98 Incurred Expenditure Cost
Nursing Homes	14,445		\$269,199,067.57
Arkansas Health Center	331		\$23,624,942.56
Human Development Centers	1,244	1,306	\$81,589,853.85
Pediatric Facilities	186	215	\$12,948,750.61
Ten Bed	355	390	\$19,405,647.24
Total:	16,561	1,911	\$406,768,261.83